

<b>Questionnaire</b> (Please print legibly or type into this form)		
<b>Logistics</b>		
Clinic Name: _____		
Clinic Address: _____		
Clinic Hours: _____		
<b>Dates Locum Required:</b> _____		
Comments: _____		
<b>Practice Operations</b>		
Does this clinic have a walk-in component?	Yes	No
<b>Daily Practice</b>		
Do you use EMR? Which one?	Yes	No
<b>Physician Preference/Practice Style</b>		
Language any special requirements?	Yes	No
<b>Patient Panel</b>		
How many patients will the locum see per/day? _____		
Clinic contact person: _____		
Phone: _____ Email: _____		
<b>Fax or email this form to Sue Cavanagh: FAX: 403.284.9518 Email: sue.cavanagh@cfpcn.ca</b>		